"Understanding the nature of inequalities and the strategies residents devise to address them are likely to be central to our understanding of, and societal efforts to eliminate, racial disparities in health."

BEING PART OF THE WORLD

Detroit Women's Perceptions of Health and the Social Environment

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We examine African American women's perceptions of the ways their neighborhoods affect health. Drawing upon data from participant observation and focus groups with Detroit residents, we examine physical, mental, emotional, spiritual, and social dimensions encompassed in women's definitions of health. The complexity of relationships between health and neighborhood emerge as women describe not only the influence of neighborhood conditions on health, but also on social relationships that have been established as protective of health. As women describe the effects of neighborhood conditions, they describe their active efforts and strategies to maintain personal and community health. We discuss implications of these results for understanding multiple, complex associations between social inequalities, neighborhood characteristics, and health. We suggest that the exploratory evidence presented here supports frameworks that posit the role of race-based residential segregation in racial disparities in health through limiting access to social and economic resources that are necessary to sustain health.

Keywords: *women's health; urban health; social dimensions of health*

Persistent racial disparities in health are among the most pressing public health concerns of our time. African Americans born in the United States in 2001 can expect, on average, 5 fewer years of life than white Americans born in the same year (National Center for Health Statistics 2003), and this disparity is even greater for African Americans who reside in urban communities with few economic resources (Geronimus et al. 1996; Geronimus, Bound, and Waidmann 1999). A well-established relationship between residence in communities with few economic and social resources and poor health (Pickett and Pearl 2001; Robert 1999) has contributed to an interest in understanding the pathways through which neighborhood contexts may contribute to racial disparities in health in the United States (Schulz et al. 2002; Williams and Collins 1995, 2001).

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In this article, we examine neighborhood effects on health from the perspective of African American women who are long-term residents of Detroit neighborhoods. We begin with their definitions of health, which extend well beyond the presence or absence of disease to incorporate physical, mental, emotional, spiritual, and social dimensions. The complexity of neighborhood effects on health emerges as women describe multiple ways that their geographical communities condition access to the material resources that promote health. They detail the implications of these conditions for social resources that are associated with health, as well as their own active efforts to change or alter existing circumstances, and to maintain health within their communities. We end with a discussion of implications for ongoing efforts to understand relationships between neighborhoods and health, and potential avenues for change.

BACKGROUND

Like many other urban industrial cities in the midwestern and northeastern United States, Detroit has experienced substantial economic and social change in the decades following World War II. Between 1950 and 2000, encouraged by federal housing and highway policies that subsidized movement out of the city, Detroit's population declined from 1.8 million people to 951,000 (Farley, Danziger, and Holzer 2000; Sugrue 1996; U.S. Bureau of the Census 1950, 2000). Business, industry, and population groups moved from central Detroit into outlying suburban areas. The proportion of the Detroit population that self-identified as African American increased from 44 percent in 1970 to 82 percent in 2000, while the actual number of African American residents increased only slightly (Lewis Mumford Center 2003).

The racially selective nature of this exodus has been well documented. As African Americans began to move into previously segregated white communities within the city, white residents of those neighborhoods responded with restrictive covenants, mobilizations, and other efforts to prevent African Americans from purchasing homes in their neighborhoods (Sugrue 1996). As these efforts were unsuccessful, white flight and relocation of employment opportunities to outlying suburban areas accelerated (Darden 1986; Darden et al. 1987; Sugrue 1996; Thomas 1997; Zax and Kain 1996). The result of these

population trends is apparent in the current status of the Detroit metropolitan area as among the most racially segregated in the country (Lewis Mumford Center 2003).

The racial segregation of the Detroit metropolitan area is mirrored in the area's economic inequalities. As manufacturing jobs that had supported a strong working class left the city, the proportion of families with incomes below the poverty line increased from 11 percent in 1970 to 29 percent in 1990 (Lewis Mumford Center 2003; Massey and Denton 1993; Sugrue 1996; Thomas 1997; Turner 1997). In 2000, 26 percent of African American and 19 percent of white Detroit residents reported incomes below the poverty line (Wayne State University 2002). These rates stand in stark contrast to the predominantly white suburbs, where just 5 percent of white residents and 13 percent of African American residents reported incomes below poverty in 2000 (Lewis Mumford Center 2003).

The social and health implications of concentrated poverty have been shown to include effects on the intellectual development of preschool and early school age children (Chase-Lansdale et al. 1997), educational risk and attainment (Connell and Halpern-Felsher 1997), adolescent behavior and achievement (Darling and Steinberg 1997; Spencer et al. 1997), child development (Jarrett 1997), and crime and delinquency (Morenoff and Sampson 1997). Neighborhood characteristics have also been linked to infant mortality (O'Campo et al. 1997; Roberts 1997), adult physical health (Collins and Williams 1999; Diez-Roux et al. 2001), and mental health (Williams and Harris-Reid 1999). The literature confirms a substantial toll in years as well as quality of life for residents of economically marginalized urban communities (House and Williams 2000).

Linking race-based residential segregation to neighborhood conditions, researchers have begun to explore the effects of segregation—particularly whites from African Americans—on pervasive racial disparities in health. Some scholars suggest that race-based residential segregation may be a "fundamental factor" affecting health: that is, one that affects multiple health outcomes through multiple pathways, by influencing access to the resources that are necessary to maintain health (Williams and Collins 2001). Understanding these multiple pathways, and the reciprocal and interactive nature of their relationship to health, is a clear challenge for those seeking to understand and reduce racial disparities in health.

A large body of epidemiological evidence has established important relationships between characteristics of neighborhoods and social and health outcomes. An equally important body of research has established relationships between individual characteristics, such as health behaviors and health outcomes, and has shown that health-related behaviors vary by socioeconomic status and by racial or ethnic group (Lantz et al. 1998). From a sociological perspective, some of the epidemiological literature may be critiqued for an overemphasis on associations between behaviors and characteristics measured at the individual level, with less attention to structural factors that influence those behaviors and characteristics and, ultimately, health. Such analyses can shift our focus away from social systems and processes, and decontextualizing behaviors and characteristics from the social relationships within which they occur (Link and Phelan 1995). Furthermore, as Mullings and Wali (2001) point out, epidemiological analyses are limited in their explanatory capacity as they strive to explain complex phenomena by reducing those phenomena to a limited set of variables and relationships. As a result, relationships between structural factors that influence access to social and material resources, with implications for individual actions and health risks, may be masked or their complexity muted.

In this article, we examine the perceptions of African American women residing in Detroit as they discuss their neighborhood environments and the relationships of those environments to residents' health. Drawing upon symbolic interactionist perspectives (Thomas and Thomas [1928] 1970) and their recent extensions in practice theory (Ortner 1989), we examine relationships between social situations, perceived meanings, frameworks for action, and human agency within particular contexts. Specifically, we seek to understand the production of health and disease within this urban context, and the active efforts of urban residents to maintain health within contexts in which their access to social, economic, and physical resources is circumscribed.

METHODS

This descriptive analysis grew from the authors' informal discussions about their prior work and thinking, that is, Schulz's (Schulz et al. 2001, 2002) research with Detroit women and health, and Lempert's

(1998) research on African American grandparents raising adolescent grandchildren. We noted, for example, overlaps as well as paradoxes in respondent descriptions of health and interpretations of social circumstances. To follow these informally identified patterns, we began some exploratory observations. Our intent was to attempt to understand health issues as they are defined by African American women living in Detroit neighborhoods. The data on which this article is based are drawn from participant observations and from focus groups conducted by the authors in Detroit in 1998-1999.

Because we, like Alexander and Mohanty (1997, p. viii), believe that the "best ideas are produced through working and thinking together," throughout the multiple stages of this project, we drew upon the combined insights of a core group of approximately twelve east and west side neighborhood residents. This core group consisted of African American men and women identified as community leaders with whom the authors had worked on previous research efforts. These community members acted as key informants, with instructive insights about the sociocultural contexts of their communities. They assisted us in developing a study design, as well as in refining our research methods and study questions.

We began our work with observations in a welfare-to-work transition program in Detroit, a group with scheduled meeting times and activities, and participants who were thinking critically about their life circumstances. In order to "understand the complex behavior of members of society without imposing any a priori categorizations that may limit the field of inquiry" (Fontana and Frey 1998, p. 56), we spent 6 months conducting participant observations and attending support group meetings, dinners, guest lectures, classes, and holiday parties. We collected information on health perceptions and interests, including observable health-related behaviors through the participant observations, and women's descriptions of health, prevention, and professional and self care. For example, we documented a number of conversations in which women identified themselves as having diabetes but also described variations from dietary recommendations made by their medical care providers.

We presented and discussed our analyses of these observations with the core group of neighborhood residents described above. On the basis of those initial analyses, we developed a short set of questions, which we discussed and refined with input from the community leaders'

group. We then used announcements, personal contacts, and church groups to recruit community members to participate in focus groups. As Naples notes (2003), dialogue among participants helps in the development of grassroots analyses of personally experienced problems that are inherently political. To facilitate such reflexive dialogue, we conducted three focus groups—two on the east side and one on the west side, with a total of twenty-four Detroit women participating. Both authors were present at all focus groups. Focus group participants were invited to consider the three main topics identified by the core group and authors: What does "being healthy" mean to you? In what ways do your neighborhoods (or the things that happen in your neighborhoods) affect your health? And, thinking about where you live, what are the things that contribute to good health? Since low levels of facilitator involvement are important in exploratory research (Morgan 1988), the authors intervened relatively little in the discussion, encouraging participants to interact with each other as they discussed the focus group topics.

Each focus group lasted slightly over two hours, and each was tape recorded and transcribed. The nonfacilitating author also took notes. Participant discussions consisted primarily of the women's descriptions of their lives within their communities, descriptions of their own health and of the observed health of their neighbors, and discussions about how their health was affected by aspects of their neighborhoods. They provided analyses, assessments, and interpretations of current events and conditions, often comparing present and past experiences.

Immediately after the focus groups, the authors discussed emergent patterns and unanticipated responses. Using Lofland and Lofland's (1995, p. 186) interrogatory formula (i.e., Of what category is the item before me an instance? What can we think of this as being about?), we independently content coded the transcribed data from the focus group discussions. Content codes captured what C. Wright Mills (1959) identified as the distinctions between private troubles and public issues. For example, we developed a code, *eating alone*, reflecting a range of dietary consequences related to individual circumstances. *Eating alone* was simultaneously linked to other codes like *neighborhood dissolution* reflecting more public levels of problem and analysis. Through further intensive dialogue and engagement with existing literatures, we brought these coded categories together in the descriptive analysis presented here.

Although the women involved in the welfare-to-work transition program and the focus group participants all identified as African American, they were a diverse group on dimensions of interest to this study. For example, they ranged in age from mid-twenties to early eighties. All were mothers, many of grown children, and many had lived in their neighborhoods all their lives. Others had left the city for several years and returned to raise grandchildren, and still others had moved through various housing locations within the community.

We discussed preliminary analyses from both the focus groups and participant observations with the core group of neighborhood leaders, and insights from that group were also incorporated into this analysis. As noted earlier, the analysis presented here is primarily descriptive and does not achieve criteria for universal claims. Nonetheless, it is significant in focusing attention on the implications of multifaceted changes in neighborhood conditions that have been documented in many northeastern urban areas over the past several decades (Jargowsky 1997; Sugrue 1996; Wilson 1987). Women's perceptions of their social and physical surroundings and their active efforts to sustain health within the context of their communities provide essential insights into the conditions themselves as well as the actions taken by resourceful individuals in their efforts to create health within those contexts.

In the ensuing sections, we outline dimensions of women's conceptualizations of health, the strategies they used to maintain and promote health, and the connections they made between their neighborhood contexts and health outcomes. In our discussion of these results, we draw from sociological and public health literatures to deepen our understanding of relationships between the physical and social environments and the holistic definitions of health presented in the following sections.

SOCIAL DIMENSIONS OF HEALTH: "BEING PART OF THE WORLD"

As women described what health meant to them, they offered conceptualizations that were multidimensional and interconnected. They spoke of health as encompassing both mental and physical activity, as "how you feel," "what your thought process is," and, as emphasized

often, social engagement and interaction: "[Being healthy is] your everyday participation in the world really. Being part of the world, and the way to even stay in the world is to be healthy." Specifically delineating the nature of health, a focus group participant noted, "Being healthy means overall well development, physically, mentally, all of that you know. Free from diseases or illnesses, a well-balanced person." These definitions emphasize health as social, developmental, and contextual. To be healthy meant to be able to participate in individual, family, and community activities.

Focus group participants were also well aware of, and in fact recited, the behavioral "rules" for maintaining physical health that pervade local newspapers, magazines, and popular culture. One participant noted: "You are supposed to eat right, you are supposed to exercise." Another respondent summarized dietary guidelines for good health, saying:

> Well, you have to get your green leafy vegetables, your starches, your carbohydrates, your protein, your iron. A lot of vegetables are good in terms of vitamins and iron and minerals. And fried foods, that's not good for your diet. I know what you're *supposed* to do.

Others echoed and reinforced this point, and one woman wryly summarized the discussion by saying, "It's always easier to do the *wrong* thing than it is to do the *right* thing."

As women described what they should do, they also identified challenges that they faced in their efforts to promote wellness. They offered analyses that anchored health firmly in social as well as structural conditions of the neighborhoods in which they lived. Their analyses ranged from the macrostructural to the microsocial, and encompassed complex relationships in which health was central to social integration and participation, at the same time that social integration and participation were central to maintaining health. These connections are described in detail in the following sections and embrace a wide array of factors, including access to nutritious foods, the impact of neighborhood safety and infrastructure on physical activity, educational and employment opportunities, and social integration and support. Each has been shown to be independently associated with health (Brownson et al. 2001; Heaney and Israel 1997; House and Williams 2000; Yen and Syme

1999). Less evident in the literature are residents' analyses of the complex interactions between those factors and neighborhood contexts, or the actions residents take to promote health within those environments.

NEIGHBORHOOD CONDITIONS, SOCIAL RELATIONSHIPS, AND HEALTH

Women who participated in this study described reciprocal interactions between health and social relationships. Social interactions were perceived as an integral component of health, and health as essential to the ability to maintain social relationships and valued social roles. Furthermore, participants clearly located health and social relationships within the structural contexts of their neighborhoods and within broad sociohistorical contexts. The implications of changes in community infrastructure described by the focus group members, for example, ranged from decreasing access to fresh foods to decreasing access to health care providers, as hospitals, health care professionals, and pharmacies relocated into outlying suburban areas.

"*That broke down the community.*" The associations between economic changes, demographic transitions, and health described in the "Background" section of this article were articulated by participants who were longtime residents of Detroit neighborhoods. One focus group respondent described the dislocations in her neighborhood that resulted from the transfer of employment opportunities to suburban areas, saying, "The people who were capable of buying a home—they moved in[to] the area where the money was coming from and that broke down the community."

Community has multiple meanings and interpretations (Cohen 1985), and "broke down the community" shares those complexities. In this section, we focus on one meaning of community that was emphasized in the interviews: changes in community infrastructure and material resources associated with the flight of jobs and the loss of a stable middle class that have implications for access to the material resources that affect health. In the following section, we examine a second meaning of "broke down the community" that emerged through the study, one that focuses on changes in social relationships within these neighborhoods. There again, we examine implications for health.

The outmigration of employment opportunities and middle-income residents from Detroit between 1950 and 2000 had profound implications for the community members who remained in the city. Concentrations of poverty increased, property values stagnated, and much of the city's tax base moved to outlying suburban communities (Farley, Danziger, and Holzer 2000; Sugrue 1996). These changes, in turn, affected the institutions that support community life, including police and fire-fighting forces, banks and lending institutions, retail outlets (grocery, hardware, clothing stores), churches, city maintenance, recreational facilities, and schools (Sugrue 1996).

Study participants clearly linked the deterioration of retail goods and services available in their communities to socioeconomic transitions in which banks and retail businesses followed Detroit residents and industrial employers to outlying areas. For example, the exodus of grocery stores from Detroit neighborhoods left smaller convenience or party stores in their wake. Focus group participants described the reduced range of items, of varying quality and often higher prices, in these stores. They voiced broad agreement that "there's rotten food in some of those stores." Residents of neighborhoods with high concentrations of poverty are disproportionately likely not to have cars (U.S. Bureau of the Census 2000), reducing further their ability to access produce in stores outside of their neighborhoods. One focus group participant in her late seventies described taking two buses to reach a supermarket with produce of acceptable quality. She said, "I get on the bus and ride the bus out there [to the suburban supermarket] and things that I want to [I] bring back on the bus." The amount of effort required to obtain high-quality produce is certainly a factor in the lament expressed in the preceding section that "it's always easier to do the wrong thing than it is to do the right thing" when it comes to nutrition. There is further epidemiological evidence that proximity to grocery outlets is associated with the probability that individuals meet dietary recommendations for fruit and vegetable intake (Troutt 1993; U.S. House Select Committee on Hunger 1990).

Another focus group participant explicitly connected the poor quality of services and resources available in neighborhood retail outlets with race, with general agreement from others in her focus group, saying, "They just don't care what they put there. I feel it's because we are black, the community is black." Implicit in her statement is the loss of the black-owned retail businesses that characterized predominantly

African American communities in Detroit in the 1950s and 1960s. Substantial evidence provides support for study participants' perceptions that the lack of quality services and products was related to the racial composition of their communities. Economic disinvestments and reduced quality of goods and services occur disproportionately in highly segregated urban neighborhoods (Darden 1986; Jaynes and Williams 1989; Sugrue 1996), and appear to be reinforced by racial stereotypes (Zax and Kain 1996).

Similarly, focus group members described the implications of redlining, a discriminatory institutional practice outlawed following World War II, in which banks refused home mortgages for residents of selected areas. For example, one woman noted, "Because of the redlining, a lot of banks didn't make loans in the community." Redlined areas were disproportionately areas in which African American homeowners resided (Sugrue 1996). Although redlining was outlawed in midcentury, its effects on property values and returns on investments in homes and communities continue (Conley 2001a, 2001b). African Americans are disadvantaged in terms of wealth or financial assets when compared with whites, even when controlling for income (House and Williams 2000; Williams and Collins 2001). Income, education, and wealth show well-established and persistent relationships to health outcomes, and the literature supports these focus group participants' assertions that race-based residential segregation and redlining—even well after the removal of supporting legislation—continue to contribute to racial disparities in socioeconomic status and consequently to racial disparities in health (Conley 2001a; Williams and Collins 2001).

Institutionalized discrimination has also severely constrained the range of options available to community residents, setting off a chain of actions and reactions that ultimately curtailed and/or limited the services of public institutions. In the face of a declining infrastructure, women described the challenges of "trying to raise children in areas where there's nothing for them to do." Neighborhood recreation centers that had previously offered safe and supervised environments for children after school were closed or were operated with reduced staff and hours. In addition, the loss of viable employment opportunities within or near African American communities meant that entry-level jobs previously available to youth were lost to the suburban rings. Others have noted that job migration out of urban areas reduced opportunities for young neighborhood men and women to develop early labor market

attachments and the self-pride of economic independence, as well as the socialization benefits of work with adult mentors who were often highly skilled and highly paid (Coontz 1997; Wilson 1987). "Nothing for them to do" is not an empty phrase. It reflects the unraveling of the social fabric that supports youth in the community.

Study participants noted in detail the ways that public institutions were often woefully inadequate to the task of supporting community life. Women offered story after story of the inadequacy of public support, where the "law-abiding majority has lost control of public space" (Fine and Weis 1998, p. 165). The following exchange from one focus group highlights the frustration of community residents:

R1: [A man was] stripping the aluminum siding off the house. The police never came. We called about 'em stripping aluminum siding off the house. And, I mean the man was taking his time and tearing it off, and fold it up, and putting in a, he didn't have a truck. He had a grocery basket!
R2: So he was by foot.
R1: We called the police. When that man got through, he did this whole one side of this house and ended up—
R3: Was it a vacant house or somebody was in it?
R1: It was vacant, but the people that owned the house had just put the aluminum siding up two years before. . . . But this man had the time, before the police response, to tear down this whole side. Bend this stuff up. Stuff it in this shopping cart. The ones he couldn't get in the shopping cart, he laid down, took his shopping cart and left. About that time, lo and behold, here comes the police. No, we told 'em, well evidently, he'll be back because he laid these down. So if you circle the neighborhood, you'll probably catch him. The man came back and got his stuff. But the police never came back.

The perception that the police and other city services could not be counted on to respond effectively to calls for assistance pervaded these interviews. Women described their efforts to get city officials to enforce health measures in the schools, to enforce food safety regulations, to collect garbage. We do not present these findings to lay blame at the feet of the police force or other city services within Detroit. To the contrary, a similar erosion of the orderliness of the public domain has been described by others, including Fine and Weis (1998) in their research in Jersey City and Buffalo, and Bourgois (1995) in a study in East Harlem.

Our intention here is to draw attention to the multilayered impacts of the processes that have drawn capital out of urban communities, affecting not only the material conditions of residents' lives, but also the institutional supports for community life.

Erosion of the infrastructure that supports community life has multiple implications for health. One sixty-year-old woman described her neighborhood as health enhancing, while an acquaintance in the same focus group described her neighborhood as having negative consequences for her health. Asked to describe the difference, the latter pointed to the former, saying, "Where *she* lives does contribute to her good health because she can walk a lot of places, and she does walk. [But in my neighborhood] I ride to the store if its' around the corner." Concerns about physical safety and social order were linked to lack of confidence in police responsiveness, as well as lack of municipal supports. The ineffectiveness of public institutions in monitoring and enforcing local ordinances, and in maintaining city services, contributed to illegal garbage dumping and to the failure to replace burned-out streetlights in a timely manner. Thus material conditions of the neighborhoods—dumped refuse in sidewalks and empty lots, inadequate lighting, and ineffective policing of public spaces—contributed to residents' curtailing both social and physical activities, such as yard work, walking in their neighborhoods, and informal socializing with neighbors.

"*Closed-door policies*." In addition to the changes in neighborhood infrastructure, women also described a second meaning of the phrase "broke down the community," one that focused on the implications of these changes in community infrastructure for the social relationships that are also encompassed in the term "community." Women repeatedly linked changes in neighborhood conditions to what they called a "closed-door policy," described as the sense that "when you knock on a person's door, they feel as if 'you're intruding in my business,'" a sort of guarded wariness that mitigated conversation and contact with other neighbors. The following exchange is illustrative of this concern as well as the push-pull factors that women residents weighed in their interactions with neighbors:

R1: Now we're in a position where you can go visit the neighbor, but you can't go inside. And that's pitiful.

Interviewer: What keeps people from going inside?

R1: Because you don't know who those people are and what they're doing.
R2: To piggyback off that . . . you don't want them [teenagers] to come in your house, because you don't know if the kids are going to later come in your house without permission to "shop" in your house.

As Fine and Weis (1998) have noted in their research with residents of northeastern cities, women sometimes found themselves positioned as guards, monitoring entrée into their homes and attempting to ascertain which neighbors they might be able to trust. At the same time, they named the consequences of such wariness, recognizing their contribution to the lack of the very social ties that enabled trust to develop. When being healthy means "being part of the world," macrosocial processes that create conditions that contribute to isolation, mistrust, and fear also undermine the social networks and opportunities for interaction that have been established as protective of health. Women's awareness of the pernicious nature of these factors, and their implications for health, was summarized by this focus group participant: "So that closing yourself in, that would have to enter your health physically and mentally, because we're people that have to congregate and talk and listen to other people's opinions."

Women understood and articulated the cycle involved with closing doors—literally and figuratively—on social connections within the neighborhood, and they drew connections to health. Neighborhood conditions that were, in and of themselves, sources of distress or worry also conspired to undermine the social relationships that offered integration and support. In the absence of trust in other neighborhood residents, the temptation to curtail social engagement and limit social contacts was one that women went to great lengths to resist. In the following section, we discuss women's substantial efforts to develop and maintain social networks and to engage other adults and children in those networks, building and strengthening "the ties that bind the Black community together" (Dodson and Gilkes 1987).

"IT'S HARD TO HIT A MOVING TARGET": STRATEGIC ACTIONS TO PROMOTE HEALTH

Women's descriptions of their neighborhoods are laden with what Fine and Weis (1998, p. xx) identify as "the language of pain and possibility." Study respondents put forward a vision of community that

superceded their present circumstances, in which a past—"We used to be more open, more family oriented. Everybody got together"—was contrasted with a present: "We don't have a social thing going on in the community." Strategies designed to change the conditions of the community were often framed against a nostalgic past in order to articulate the potential for the future, and that vision was undeniably social. Women drew upon a variety of frameworks and strategies to support each other in their efforts to "be part of the world" in the face of the macrosocial structural challenges we have already described.

Strategic efforts to combat agoraphobia. In their research with residents of low-income communities in the Northeast, Fine and Weis (1998, p. 197) coined the term "strategic agoraphobia" to describe maternal maneuvers to keep children indoors and off the streets, and hence protect them from the dangers that they might encounter there. Detroit women noted similar processes that affected both themselves and their children. They described curtailing their own activities out of doors and their efforts to protect their children, often recognizing the contradiction in such actions for their children's ability to develop the social connections that these mothers valued so highly as an aspect of good health. However, women also described strategic efforts to counter this enforced isolation, to remain active themselves, and to "Keep them [youth] active. Keep them busy. Keep them out of trouble."

Many of their efforts with regard to their children were geared toward activities that Coontz (1997, p. 13) has described as "responsible, socially necessary work, either in or out of the home, and for moving away from parental supervision without losing contact with adults." They included specific strategies for engaging young men and women in activities within their communities, schools, and churches, explicitly designed to integrate young people in meaningful ways with others in the neighborhood.

Women did not limit their concerns about those who had "nothing to do" to young people—nor did they limit their efforts to engage community members in building connections to youth. The following example from a focus group is illustrative:

> R: And in our community, you see men congregate on a corner. They have couches and they already burned the wood. And you see more and more of that now, you see, because they have nothing to do.

I: Men who are homeless?
R: No, men who are laid off. Men who don't have a job. . . . But we as women need to tell them that they could be doing something else with they time, like mentoring these young, these young men that need to be coming up into the world.

Recognizing the institutional obstacles that often conspired to deny African American men employment, women also made it clear that "we need them to come step up to the mat . . . they need to start being men and mentors to these young men." They described their efforts to engage men in meaningful roles in the community, roles that were not dependent on the labor market—notoriously undependable for African American men. Efforts to engage unemployed men and young adults in activities that would also integrate them into the community are in keeping with the emphasis on social connectedness that was fundamental to women's visions of health and well-being. Furthermore, women's efforts to sustain their own social networks and to incorporate others in these networks can easily be viewed as health-promoting strategies, given the well-established literature that links social integration and social support to health (Yen and Syme 1999).

"*I keep active*." Women also described multiple activities that worked to extend and strengthen their own social networks, and to combat social isolation. They described the importance of "staying active" for health and well-being, and worked at remaining actively involved with friends, family, and community groups. One fifty-five-year-old participant stated, for example, "I go walking every day." More often than not, "keeping active" was framed not simply in terms of remaining physically active, but also in terms of social activity. For example, one great grandmother said: "I keep myself busy, and I help to take care of my great grandbaby. . . . I'm busy all day, and so it keeps me active. When you're active, you don't have your mind floating around from one place to the others."

Here "being active" is framed as continued engagement in a socially valued role, one that maintains a connection to younger generations. This explicit connection between remaining active and retaining mental well-being, keeping focused, and not "floating around from one place to the others" is one that resonated through the women's discussion of health and well-being.

Women described many activities that highlighted the importance of shared events in creating and maintaining social bonds: shared meals played a central role for many. One older woman whose family was grown and who now lived alone said, "I don't mind *living* alone, but I hate to *eat* alone." And another described the effects of transitions in family roles on her efforts to eat a healthy diet as follows:

> When I had my family, I made a big meal every day. . . . I cooked a lot. But now that I'm by myself, whatever I see, you know, [I] just grab it. I know I'm supposed to eat right. And I do—I try, but I don't all the time. Last night I had a piece of fish and some slaw, and I didn't need either one. The fish because it was fried, and I'm not supposed to eat fried food, but I didn't want to cook and so [the fish was] ready and so that's what I did.

Women regularly scheduled meals with friends and acquaintances or ate their "main meal" at lunchtime with friends or coworkers. Some developed friendships with other women with whom they planned dinners. And some dined frequently at the homes of family members. They reported working actively to create opportunities for social events that afforded opportunities for engagement with family members, friends, church members, coworkers, and/or neighbors. Such opportunities were clearly of utmost importance to the women in this study. Both the focus on social interaction and the strategies that women developed to combat social isolation in these descriptions provide insights into the importance that they placed on social networks and social support as health-enhancing resources.

Pattin' and turnin'. Even as women spoke of the strategic actions they took to promote social environments that would be conducive to health, they also described their efforts to confront the hopelessness and despair that they sometimes experienced when faced with overwhelming life circumstances. The following exchange between two focus group participants occurred when the first participant described someone as "pattin' and turnin'."

R1: That's when there's nothing you can do and you keep thinking "Well, I'll do this," but you'll start and there's nothing you can do. So you call it pattin' and turnin', 'cause you go this way and nothing will work and you go that way.

R2: Between a rock and a hard place.

Faced with the dissolution of structural supports for community life and the subsequent implications for the very social networks that might alleviate some of the impact of that loss, it is no surprise that women sometimes found themselves "pattin' and turnin'," going this way and that way in search of an effective course of action.

And search they do. Even when confronted with the seeming impossibility of action, as with one woman who described herself as "so stressed I'm numb," women also described their dogged determination to "keep on going":

R1: I keep on going 'cause I found it don't stop anything. You just go right on through. I don't care what it is, that's what I'm doing.
R2: OK. Now she gives the same answer that I get because my mother always told me it's very hard to hit a moving target. And if you keep on moving and keep on going, you can change. If nobody else, you can change your situation.
R3: That's right.
Interviewer: Who supports you? You do it all by yourself?
R2: God.
R1: I rely on God.
R2: Because you find yourself praying a lot when you get depressed.
R3: Right—a lot.
R2: I mean, when you stop and think about it, you have to do something. I mean, you can get stopped right in a mud puddle here. And you're thinking you got a car, a beautiful white car, and you've got to get out of the mud. What are you going to do with it? Or, what am I going to do with it? I have a good time with that. I look at that car down there and then I go to find me a shovel and shovel that stuff out of there.
R1: You do what you have to. That was the greatest answer. When the situation arises, you handle it.

In this conversation, women demonstrated the active exchange of social support as they encourage one another to stay in motion doing "what you have to do." This social support also reflects and reinforces cultural frameworks that emphasize active efforts to "get out of the mud," as well as reliance on prayer in the face of seemingly insurmountable odds. Women affirm each other, and remind each other of the words of their own mothers admonishing them not to stop, to continue moving, to be a moving target, to do what you have to do, to handle it.

"Being active," as described by women in these focus groups, involved a range of activities. These included active efforts to work in their communities to create change. They also included substantial efforts to forge and maintain relationships that offered opportunities to give and receive instrumental and emotional support, activities that helped to extend social networks and the tangible and intangible resources available through those networks, for example, affirmation, information, and material resources. The care and energy that women devoted to developing, strengthening, and sustaining friendship networks were apparent as they described the importance they attached to remaining active. Even as they interacted in the focus groups, women offered each other support and affirmation in their efforts to continue to struggle actively against the odds. This focus on "doing" may, in fact, reflect a paradox when it comes to health. There is ample evidence to support the idea that those who remain active in the sense of remaining socially engaged may experience health-promoting benefits, in part through the social networks and social support that women in this study described as integral to their health (Heaney and Israel 1997; House, Landis, and Umberson 1988; Yen and Syme 1999). However, where remaining active becomes "pattin' and turnin'"—that is, continuing to strive when there is no place to turn—health outcomes may be less than positive (James and Thomas 2000; Mullings and Wali 2001). Such outcomes reflect the obdurate nature of the social conditions that women face as well as the persistence of their efforts to create life-affirming and health-enhancing opportunities within those environments.

DISCUSSION

We have presented an analysis based on African American women's descriptions of what it meant to them to be healthy, and how characteristics of their neighborhoods influenced individual and community health. The perception that health was "being part of the world" was a central organizing theme in this analysis. Good health was described as inherently social, not an isolated or individual phenomenon. For study participants, being healthy involved being actively engaged in family, church, friendship networks, and community or other social groups. Beginning with women's own emphasis on health as "being part of the world," we examined the multiple connections they made between eco-

nomic divestment, social (dis)integration, and the ability of their communities to provide material and social resources necessary to maintain health.

Women offered analyses of the social and economic processes that "broke down the community," drew people and capital out of urban neighborhoods, and altered their lives. Household income was affected as access to quality education, entry-level jobs, and long-term employment possibilities deteriorated. Given the persistence of relationships between socioeconomic status and health (House and Williams 2000; Link and Phelan 1995), these changes have profound implications for health. Simultaneously, the infrastructure that supported community life, including retail outlets, banks, police and fire departments, and recreational facilities, eroded with direct and indirect consequences for access to health-supporting resources. Defining health as "being part of the world," women reiterated the corrosive effects of these structural changes on their abilities to "congregate and talk and listen to other people's opinions," on their opportunities to develop and sustain social networks.

Recognizing the pernicious effects of the inability to trust either institutional supports or neighbors, women sought to develop, strengthen, and sustain ties within their families, churches, and communities. They sought out arenas in which they could congregate, listen, and talk to each other, recognizing and valuing the instrumental support, affirmation, and solidarity that developed through interaction. Such strategies have long been central to African Americans' efforts to sustain and affirm a positive sense of identity within a racist context (Collins 1990; Dodson and Gilkes 1987). These relationships offered not only day-to-day social support, but also served as a foundation for women's efforts to monitor and police neighborhood conditions, and to "dig out of the mud" as necessary.

Women described countless individual actions that kept them in constant motion, doing something, doing what they had to do for self and for others. While they clearly articulated the links between broad structural change and health, they focused their energies at a more local level, building and maintaining social relationships and working to improve neighborhood conditions. They relied upon, and keenly felt the limits of, resources that have long been sources of support within African American communities—social support networks, the black church, and grandparents (Israel et al. 2002; Lempert 1998; Lincoln

and Mamiya 1990; Mukenge 1983; Poe 1992; Stack 1974; Walker and Wilson 2002).

In the face of those challenges and the limitations of resources, women also described their efforts to maintain mental health and to stave off the hopelessness and depression that some described experiencing. Economic divestment from racially segregated communities may at times overwhelm even residents' strong commitment to social integration and action for change. As structural supports erode, and with them the responsiveness of political and municipal systems to residents' requests for assistance (Cohen and Dawson 1993; Cohen and Northridge 2000), women turned increasingly to their own active efforts, to social support and the resources that could be mobilized within those networks, and to spiritual resources (Harburg et al. 1970; Israel et al. 2002; James, Schulz, and vanOlphen 2002).

The unshakable commitment to personal and collective action reflected in this study resonates with reports of others who have studied African American women's efforts to sustain themselves and their families under structural conditions that deny them the resources to maintain well-being (Collins 1990; Fine and Weis 1998; Mullings and Wali 2001). Geronimus (1992) has coined the term "weathering" to describe the toll taken by day-to-day exposure to, and efforts to cope with, life conditions in which there are many challenges and limited resources. There is some evidence that active responses to adversity, enacted in response to unyielding structural conditions, may contribute to increased risk of negative health effects (James et al. 1987, 1992; Mullings and Wali 2001). James initially coined the term "John Henryism" to describe this phenomenon, based on the legend of John Henry, the steel-driving man who loses his life in an effort to beat the "machine" (1994). More recently, Mullings and Wali (2001) have described what they term "Sojourner syndrome"—after Sojourner Truth—to describe African American women's active efforts to confront overwhelming economic, political, and social challenges. Evidence in the quantitative literature regarding associations between constant high-effort responses to stressful life conditions, socioeconomic status, and health outcomes has varied by context or region, gender, and patterns of economic development (Dressler, Bindon, and Neggers 1998; James et al. 1987, 1992; James and Thomas 2000; Markovic et al. 1997). This study suggests that the relationships are complex, and that further effort to disentangle the patterns will be central to an under-

standing of the contributions of structural inequalities, neighborhood conditions, human responses to those conditions, and health.

Relationships between strategic actions to promote health as well as contexts that are supportive of health, social, and economic characteristics of neighborhoods, as they are described in the preceding pages, are complex and bear further study. Understanding the nature of inequalities and the strategies that residents devise to address them are likely to be central to our understanding of, and societal efforts to eliminate, racial disparities in health. For example, what do persistent active responses to adverse conditions tell us about the enduring nature of social inequalities? Does the responsiveness, or lack thereof, of institutions to individual or collective efforts for change influence the health implications of such efforts? Do health effects vary with the particular strategies undertaken in response to those structural conditions (e.g., individual versus collective strategies)? The degree of isolation or integration of residents of segregated communities from political, economic, and social resources, and the extent to which they are able to devise alternative forms of social influence, may have implications for structural conditions, strategic responses, and health outcomes. Further efforts to elucidate these and related questions will play an essential role in the identification of strategic opportunities to reduce racial disparities in health.

CONCLUDING COMMENTS

Women's descriptions of their neighborhoods and their active efforts to sustain health within those contexts offer important insights into the conditions themselves and the creative actions of resourceful individuals faced with difficult life circumstances. While their own discussions of "being part of the world" focused on social networks and neighborhoods, as did the majority of the actions that they described, the phrase "being part of the world" also resonates at a more macro level. Women offered an analysis of neighborhood change and health that was sociological in its attention to the broad economic trends, legal decisions, and political efforts shaping the characteristics of their communities, their lives, and their health.

Williams and Collins (2001) describe race-based residential segregation as a fundamental determinant of health, one that influences

health by influencing access to the resources that maintain health. They note that

> the physical separation of the races by enforced residence in certain areas is an institutional mechanism of racism that was designed to protect whites from social interaction with Blacks. Despite the absence of supportive legal statutes, the degree of residential segregation remains extremely high for most African Americans in the United States. (2001, p. 57)

Racial segregation and concomitant economic divestment circumscribe access to social, economic, and political resources, profoundly influencing residents' ability to "be part of the world" and their "everyday participation in the world." While the analysis presented here highlights women's active efforts to maintain health within the context of their neighborhoods, the limits of personal as well as political resources suggest that those actions may have limited effects on the structural conditions that shape neighborhood conditions. The persistence of segregation even in the absence of supportive legislation highlights the importance of active efforts to understand and disrupt the processes through which race-based residential segregation and the associated withdrawal of life-sustaining resources from predominantly African American communities are perpetuated.

NOTES

1. The loss of employment opportunities for African American youth within Detroit communities has also been linked to the decline of the African American business community following the Civil Rights movement and urban renewal efforts of the 1970s. See Sugrue (1996) and Walker and Wilson (2002).

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